

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 122260-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 13th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 8, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the request and asked for the information it used to make its final adverse determination. The Commissioner received BCBSM's response on July 13, 2011. On July 18, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request. BCBSM provided additional information on July 25, 2011.

The issue in this external review can be decided by a contractual analysis. The Petitioner's health care benefits are defined in the BCBSM *Flexible Blue Group Benefit Certificate* (the certificate) as amended by *Rider Flexible Blue D 2000/4000-P, 4000/8000-NP* and *Rider HCR-PCB Health Care Reform – Preventive Care Benefits*. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On March 18, 2011, the Petitioner had a colonoscopy and related anesthesiology and

pathology and diagnostic services from participating providers. BCBSM covered the colonoscopy without any cost sharing (i.e., copayments, coinsurance, or deductibles) and, during the internal grievance process, agreed to also cover the anesthesia services without any cost sharing. However, BCBSM subjected the pathology and diagnostic services (CPT code 88305) to the Petitioner's \$4,000.00 annual panel deductible.

The Petitioner appealed BCBSM's decision. BCBSM held a managerial-level conference on June 1, 2011, and issued its final adverse determination dated June 27, 2011.

III. ISSUE

Is BCBSM required to cover the pathology and laboratory services related to the Petitioner's colonoscopy without any cost sharing?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that the federal Patient Protection and Affordable Care Act (PPACA)¹ requires that all the claims related to his colonoscopy be covered without any cost sharing on his part. In his request for external review the Petitioner wrote:

I received a screening colonoscopy because I turned 50. Under federal law, my policy includes coverage for this cancer screening exam, without co-pay or deductible. Blue Cross refuses to include the biopsy reading of the polyp found in its definition of a "screening for colo-rectal cancer." Of course, this is the most essential part of a colo-rectal cancer screening.

BCBSM's Argument

BCBSM explained its position in its response to the request for external review:

It remains BCBSM's position that [the Petitioner's] claims of March 18, 2011 were processed correctly which includes the application of the deductible in question. BCBSM confirmed that procedure code 88305 is not payable as a preventive service and therefore based on the language of the applicable Certificate and Riders, the deductible was appropriately applied.

In this appeal [the Petitioner] appears to argue the lab services associated with the colonoscopy he received should not be subject to a deductible. [He] appears to further argue the National Health Care Reform (NHCR) legislation provides for this procedure to be paid in full (no out-of-pocket cost for the member). While it

¹ Pub. L. No. 111-148, 124 Stat. 12 (2010).

is conceded the colorectal cancer screening procedure is covered under NHCR, it is BCBSM's position the subsequent pathological testing is not and therefore subject to deductible. Finally, it is important to note that BCBSM cannot adjust procedure codes billed. BCBSM was billed procedure code 88305 which is not a preventive service and therefore would not be subject to the requirements of the NHCR legislation.

BCBSM says that CPT code 88305 ("surgical pathology, gross and microscopic examination") is not a procedure that is on its list of preventive care services and is therefore not provided without cost sharing. BCBSM also says that the Petitioner had not met his \$4,000.00 annual panel deductible (required by *Rider Flexible Blue D 2000/4000-P, 4000/8000-NP*) at the time he had the colonoscopy so it correctly applied its approved amount to that deductible.

Commissioner's Review

PPACA requires health plans and health insurers offering group or individual health insurance coverage to provide benefits for certain preventive care services without imposing cost-sharing requirements. See 42 USC § 300gg-13 and regulations at 45 CFR § 147.130.

The required preventive care benefits are those recommended by the United States Preventive Services Task Force (USPSTF) and include "screening for colorectal cancer." The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50.

In order to comply with federal law, BCBSM amended the Petitioner's certificate with *Rider HCR-PCB Health Care Reform – Preventive Care Benefits* which says:

This rider adds benefits for the immunizations and preventive care services listed below and for additional benefits that are mandated under the Patient Protection and Affordable Care Act (PPACA) at the time the services are performed.

* * *

- **For members enrolled in one of the following certificates:**

- Flexible Blue Group Benefit Certificate (Form No. 8199) [*the Petitioner's certificate*]

* * *

We will pay 100 percent of our approved amount, not subject to any deductible or copayment requirements, for services obtained from a panel provider.

* * *

"Colonoscopy" under the subsection "Physician and Other Professional Provider Services That Are Payable" under the "Coverage for Physician and Other Professional Provider Services" section of your certificate is added or amended as follows:

Benefits for colonoscopy services are payable at 100 percent of the BCBSM approved amount as follows:

- **We pay for one routine screening colonoscopy once per member per calendar year.**
 - Routine screening colonoscopies are limited to once per member per calendar year. Medically necessary colonoscopies are not limited to once per member per calendar year.

NOTE: For members enrolled in a PPO product, services can be performed by a panel or nonpanel provider. Services by a nonpanel provider are subject to any nonpanel cost-sharing requirements of your certificate.²

Subsequent medically necessary colonoscopies performed during the same calendar year by panel or nonpanel providers are subject to deductible and copayment requirements.

The certificate entitles the Petitioner to a routine screening colonoscopy once per calendar year with no cost sharing. BCBSM does not dispute that the Petitioner had a routine screening colonoscopy on March 18, 2011.

According to the Petitioner, a polyp was removed during the colonoscopy and sent for pathology testing. It is BCBSM's position that only the colonoscopy is covered with no cost sharing; it says that the pathology examination (CPT code 88305) is subject to cost sharing because it is not a preventive service. The Petitioner argues that any pathology examination required should be included as part of a covered screening colonoscopy without cost sharing.

The Commissioner agrees with the Petitioner: a routine screening colonoscopy as a preventive care service must include a pathology examination if necessary. The Commissioner's view is in accord with this definition of preventive care:

Preventive care is a type of care that adopts preventive measures and health screenings such as routine physicals, well-baby care, immunizations, diagnostic lab and x-ray tests, pap smears, mammograms, and other early detection testing which is often covered in a health plan. It includes programs or services that can help people prevent disease and diagnose a problem early, when it is less costly to

² BCBSM has not claimed that the colonoscopy was performed by a nonpanel provider.

treat, rather than late in the stage of a disease when it is much more expensive, or too late to treat.³

Preventive care involves early detection. A colonoscopy alone does not always detect a disease or condition nor does it always permit a diagnosis. A pathology examination, if necessary, is a tool that is critical in insuring that problems are identified early, which is one of the goals of preventive care.

The federal regulations give examples of when a preventive care service may be subject to cost sharing requirements but those examples do not address the issue here. The USPSTF recommendations referenced in the federal regulations include a “screening for colorectal cancer.” That screening can be accomplished by fecal occult blood testing, sigmoidoscopy, or colonoscopy. Thus, it is not a colonoscopy that is required but a screening for cancer. The colonoscopy alone would not constitute a screening; the presence of cancer would not be established without a pathology examination.

Not all colonoscopies require pathology examinations. However, a pathology examination is an integral part of preventive care when something abnormal is found. To not include a pathology examination as part of a routine screening colonoscopy when it is medically indicated would be like saying a preventive care mammography includes the x-ray but not a radiologist’s analysis of the image.

The Commissioner finds that BCBSM incorrectly processed the claims for the March 18, 2011, colonoscopy under the terms of the certificate. The certificate’s benefit for a routine screening colonoscopy must include a pathology examination when medically indicated. However, nothing in this order should be construed to require that any treatment needed as the result of a routine screening colonoscopy must be provided without cost sharing.

V. ORDER

BCBSM’s final adverse determination of June 27, 2011, is reversed. BCBSM shall cover the Petitioner’s routine screening colonoscopy, including the pathology services, without any cost sharing, within 60 days of the date of this Order.

BCBSM shall, within seven days of providing coverage, furnish the Commissioner proof it has implemented the Commissioner’s Order. To enforce this Order, the Petitioner may report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

³ <http://definitions.uslegal.com/p/preventive-care/> (accessed January 10, 2012).

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner